Washington State Department of Social & Health Services

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA)

REVIA (NALTREXONE) AUTHORIZATION

AGENCY SECTION (TO BE COMPLETED BY THE COUNSELOR)

CERTIFIED TREATMENT AGENCY	AGENCY NUMBER

The certified treatment agency listed above certifies that the patient listed below is 18 years of age or older; alcohol or opiate dependent, with alcohol or opiate dependence as the primary addiction; and has been admitted to publicly funded chemical dependency treatment scheduled to be provided for a minimum of 12 weeks of continuous service.

COUNSELOR'S SIGNATURE	DATE	PRINT COUNSELOR'S NAME

PATIENT SECTION (TO BE COMPLETED BY THE COUNSELOR)

PATIENT NAME	MEDICAL ASSISTANCE ADMINISTRATION PATIENT IDENTIFICATION CODE (PIC) NUMBER	DATE ADMITTED TO TREATMENT	DEPENDENCY
			☐ Alcohol ☐ Opiate

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
(TO BE COMPLETED BY PATIENT)

I, _____, authorize the certified treatment agency indicated above to disclose patient identifying information, my status as a patient and their treatment recommendation to my physician and the pharmacy indicated below for the purpose of acquiring a prescription for REVIA (naltrexone).

Physician: _____

Pharmacy: _____

I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR Part 2 and Washington Administrative Code (WAC) 440-22) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall expire 90 days from the date signed. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Patient's signature: **Date:**

PHARMACY SECTION (TO BE COMPLETED BY THE PHARMACY)

I have received a prescription for REVIA (naltrexone) for the patient named above from the patient's physician and have filled the prescription as authorized. I understand that reimbursement from the Medical Assistance Administration (MAA) for REVIA (naltrexone) shall only be made under the following condition:

1. The medication is provided as part of a comprehensive treatment program as verified by the certification provided above.
2. Payment for the medication is limited to 12 weeks of continuous use. The medication is limited to a 34 day supply on each fill not to exceed three fills.
3. The pharmacy shall include the prescribing physician's MAA Medical Provider Number on the MAA billing form.
4. Record of this certification shall be kept on file at the pharmacy for MAA audit purposes. Prescriptions reimbursed by the MAA for naltrexone without this certification record on file shall be considered an overpayment.

Pharmacist's signature: **Date:**

DSHS 13-677 (02/1996) TRANSLATED

See back of form for prohibition on redisclosure of information concerning the patient or information on this form.

COPIES TO: Pharmacy Physician Treatment Agency

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING A PATIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.